US DEPARTMENT OF VETERANS AFFAIRS
**OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

## VETERANS HEALTH ADMINISTRATION

# Inadequate Staff Training and Lack of Oversight Contribute to the Veterans Health Administration's Suicide Risk Screening and Evaluation Deficiencies

National Review | 23-02939-13 | December 18, 2024

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# Executive Summary

The VA Office of Inspector General (OIG) conducted a national review to evaluate the Veterans Health Administration's (VHA's) suicide risk screening and evaluation training, adherence, and oversight procedures. Every day approximately 18 veterans die by suicide. Research indicates that 84 percent of individuals who died by suicide received healthcare services, mostly in medical specialty and primary care settings, in the year prior to death. Approximately half of those individuals did not have a mental health diagnosis.[1]

Although a national suicide prevention work group concluded that evidence was insufficient to determine the effectiveness of suicide risk screening, asking patients about thoughts of suicide or self-harm can identify patients with an increased suicide risk.[2] VHA requires standardized suicide risk screening to ensure "that the entire healthcare system is readily equipped to identify Veterans at risk for suicide, regardless of where they are receiving care, so they can be connected to life-saving resources and interventions."[3]

Since May 2018, VHA has had a standardized Suicide Risk Identification Strategy (Risk ID) process, which includes screening patients using the Columbia-Suicide Severity Rating Scale (screening). In response to a positive screening, a licensed independent provider must complete and document a comprehensive suicide risk evaluation (evaluation), which assesses overall risk, suicidal ideation, plan, intent, and behaviors; risk and protective factors; and establishes a risk mitigation plan.[4]

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[1] VA Office of Mental Health and Suicide Prevention, *2023 National Veteran Suicide Prevention Annual Report*, November 2023; Department of Health and Human Services, *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*; Brian K. Ahmedani et al., "Health Care Contacts in the Year Before Suicide Death," *Journal of General Internal Medicine* 29, no. 6 (February 25, 2014): 870-877, https://doi.org/10.1007%2Fs11606-014-2767-3.

[2] "Recommended Standard Care for People With Suicide Risk: Making Health Care Suicide Safe," National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group, accessed March 12, 2024, https://theactionalliance.org/sites/default/files/.

[3] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) et al., November 23, 2022.

[4] Deputy Under Secretary for Health for Operations and Management, "Suicide Risk Screening and Assessment Requirements," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) et al., May 23, 2018; "Frequently Asked Questions (FAQ)," Veterans Affairs Suicide Risk Identification and Management SharePoint, accessed May 1, 2023, https://dvagov.sharepoint.com/sites/ECH/srsa/Shared%20Documents/Risk%20ID/Risk%20ID%20FAQ%205.0.pdf?CT=1707161426726&OR=ItemsView&web=1. (This site is not publicly accessible.); VHA Directive 1100.21(1), *Privileging,* March 2, 2023, amended April 23, 2023; A licensed independent practitioner is "an individual permitted by law and the VA medical facility, through its Medical Staff Bylaws to provide patient care services independently, without supervision or direction, within the scope of the individual's license and in accordance with privileges granted by the facility." For the purpose of this report, the OIG refers to a licensed independent practitioner as licensed independent provider.

## Review Results

The OIG compiled screening and evaluation metrics for 137 facilities, and distributed surveys to facility- and Veterans Integrated Service Network (VISN)-level staff with Risk ID implementation, training, and monitoring responsibilities.[5]

***The OIG found that VHA requires healthcare providers to complete suicide prevention training; however, the training does not address Risk ID processes or requirements.*** Since 2008, VHA requires suicide risk and intervention training for healthcare providers. However, the training content does not include education specific to Risk ID processes and screening and evaluation responsibilities. Although VHA has developed additional training related to Risk ID processes and responsibilities, the training is not required and VHA does not monitor staff training completion. Inadequate knowledge of Risk ID requirements may contribute to decreased adherence to suicide risk screening and evaluation, an underestimation of patients' suicide risk, and ultimately a failure to facilitate risk mitigation. The OIG would expect required suicide risk and intervention training to provide information related to Risk ID screening and evaluation responsibilities.

***The OIG found that VHA has not established annual Risk ID screening and evaluation performance benchmarks and has conveyed inconsistent expectations to VISN and facility leaders and staff.*** VHA requires annual screening for all VHA patients and has established a screening clinical reminder in patients' electronic health records (EHRs) that alerts staff to conduct the annual screening.[6] The Combined National Suicide Prevention Program Metric Ambulatory Risk ID Power BI Dashboard (Combined Risk ID) dashboard includes two metrics that measure adherence to annual screening and evaluation requirements.[7]

In fiscal year (FY) 2023, the VHA national screening metric indicated 55 percent adherence and did not exceed 60 percent in any given month.[8] The same year, VHA demonstrated 82 percent

[5] The OIG excluded South Charlotte VA Clinic and Kernersville VA Clinic because the Combined National Suicide Prevention Program Metric Ambulatory Risk ID Power BI Dashboard (Combined Risk ID dashboard) did not include FYs 2022 and 2023 data.

[6] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum to Veterans Integrated Service Network Directors (10N1-23) et al., November 13, 2020. The universal screening requirement is facilitated though the clinical reminder system using the Columbia-Suicide Severity Rating Scale (screening). A clinical reminder is an EHR tool that alerts providers to clinical interventions due. "VistA Clinical Reminders Version 2.0," VA, October 24, 2006, updated September 14, 2021.

[7] As of April 2024, the Combined Risk ID dashboard does not include VHA sites using the new EHR. "Risk ID Metrics Fact Sheet," VA Suicide Risk Identification and Management (Risk ID) SharePoint, accessed February 28, 2024, https://dvagov.sharepoint.com/sites/ECH/srsa/. (This site is not publicly accessible.)

[8] A fiscal year is a 12-month cycle that spans October 1 through September 30. Fiscal year 2023 began on October 1, 2022, and ended on September 30, 2023; "VA Finance Terms and Definitions," VA/VHA Employee Health Promotion Disease Prevention Guidebook, accessed November 1, 2023, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf.

adherence to same-day completion of an evaluation in response to a positive screening. Although VHA demonstrated greater adherence to the evaluation metric, the OIG determined that the evaluation metric conveys limited information as it does not include patients that VHA clinical staff failed to screen and who may be in need of further suicide risk evaluation.

An Office of Mental Health and Suicide Prevention (OMHSP) leader stated, "we have to strike a little bit of a . . . balance and be careful to . . . not set benchmarks that are completely unachievable given the place that we're at in [Risk ID] implementation." In a November 2020 memorandum, VHA stated an expectation of 100 percent adherence, while other VHA documents reference expectations ranging from 81 to 95 percent, and the Combined Risk ID dashboard indicates that a screening benchmark is "to be determined."[9] The OIG determined that VHA has conveyed inconsistent expectations to VISN and facility leaders and staff related to Risk ID screening and evaluation adherence.

***The OIG found that VHA did not establish Risk ID setting-specific requirement performance benchmarks or monitors (except for emergency departments and urgent care).*** VHA recognized the need for suicide risk screening beyond annual screening with the implementation of setting-specific Risk ID requirements in emergency departments and urgent care, outpatient mental health, opioid treatment programs, sleep clinics, pain clinics, mental health residential rehabilitation treatment programs, community living centers, inpatient mental health, inpatient medical and surgical, and inpatient rehabilitation units. The absence of defined performance expectations and oversight of setting-specific Risk ID requirements may contribute to inadequate suicide risk screening, which ultimately results in a failure to identify patients at risk for suicide and opportunities for risk mitigation.

***The OIG determined staff encountered barriers to completing Risk ID screening and evaluation, which included (1) limited engagement of facility clinical staff, (2) lack of facility leaders' support, (3) limitations of performance data, and (4) unclear delineation of responsibilities.*** During interviews, OMHSP and Mental Illness Research, Education, and Clinical Center (MIRECC) leaders acknowledged the importance of engaging non-mental health staff who may be hesitant to screen patients due to discomfort about what to do if the screening is positive. Additionally, more than half of facility staff interviewed shared that staff perceive Risk ID as a responsibility of suicide prevention program staff. Although MIRECC leaders reported providing education and support to non-mental health clinical specialty areas upon request, the OIG determined that VHA lacked a standardized and monitored strategy to ensure non-mental health clinical specialty leaders and staff are aware of and adherent to the Risk ID screening and evaluation requirements.

[9] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum.

In interviews with the OIG, 16 facility staff described the importance of leaders' support in Risk ID process implementation and adherence. OMHSP leaders also acknowledged the importance of engaging VISN and facility leaders in Risk ID implementation.[10] In FY 2024, VHA added a Risk ID evaluation metric to the network and facility directors' performance plan to communicate expectations and ensure evaluations are completed timely following positive screenings. An OMHSP leader told the OIG that the addition of the Risk ID evaluation metric established clearer standards and "engages the uppermost levels of leadership in terms of setting expectations for performance . . . to drive performance."

Staff at 8 of 21 facilities reported limitations to monitoring Risk ID adherence due to an inability to access patient- or provider-level data. VHA provides an evaluation adherence report, which allows facility staff to view the number of missed screenings within a clinical service but does not provide patient identifying information or the name of the provider who did not complete the required screening. Facility staff told the OIG that without identifying patient and provider information, it is difficult to adequately address annual screening deficiencies, target education, and ensure provider accountability for completing required screening.

OMHSP, "in conjunction with" the MIRECC, have shared responsibility "for monitoring Risk ID implementation and providing feedback to facilities through VISN Chief Mental Health Officers." MIRECC leaders told the OIG that "the policies are OMHSP's" and MIRECC has a role in Risk ID monitoring but does not have the authority to establish policies or ensure Risk ID implementation and that "the leadership at each facility, really, ultimately has responsibility for making sure [Risk ID is] implemented."

The OIG concluded that the shared responsibility for addressing Risk ID deficiencies has contributed to a lack of clarity related to accountability for Risk ID adherence monitoring and performance improvement. The OIG would expect a clearly delineated process for reporting adherence and identification of individuals responsible for addressing deficiencies. The absence of clear processes and responsible individuals has resulted in failure to identify patients potentially at risk for suicide and provide critical risk mitigation.

The OIG made six recommendations to the Under Secretary for Health related to suicide risk and intervention training, suicide screening and evaluation adherence benchmarks, setting-specific Risk ID monitoring, effectively addressing barriers to Risk ID non-adherence, non-mental health clinical specialty leaders' awareness of Risk ID requirements, and clear identification of Risk ID monitoring and oversight responsibilities.

[10] The OIG selected 21 facility staff members with Risk ID responsibilities from facilities with the lowest and highest suicide screening and evaluation adherence as well as facilities with the greatest increases and decreases in adherence between or across FYs 2022 and 2023. The 16 facility staff described, unsolicited, the importance of leaders' support.

## VA Comments and OIG Response

The Under Secretary for Health concurred with the recommendations and provided acceptable action plans (see appendix C). The OIG will follow up on the planned actions until they are completed.

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for Healthcare Inspections

# Contents

# Abbreviations

| | |
|---|---|
| EHR | electronic health record |
| FY | fiscal year |
| HCS | Healthcare System |
| MIRECC | Mental Illness Research, Education, and Clinical Center |
| OIG | Office of Inspector General |
| OMHSP | Office of Mental Health and Suicide Prevention |
| VAMC | VA Medical Center |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Introduction

The VA Office of Inspector General (OIG) conducted a national review to evaluate adherence to the suicide risk screening and evaluation processes, as required by the Veterans Health Administration (VHA).[1] Specifically, the OIG evaluated suicide risk screening and evaluation training, adherence, and oversight procedures.

## Background

Suicide prevention is the VA's top clinical priority.[2] Every day approximately 18 veterans die by suicide and many more individuals experience suicidal thoughts or engage in suicidal behaviors.[3] Reducing deaths by suicide requires detecting risk early and effectively.[4] Although a national suicide prevention work group concluded that evidence was insufficient to determine the effectiveness of suicide risk screening, asking patients about thoughts of suicide or self-harm can identify patients with an increased suicide risk.[5] VHA requires standardized suicide risk screening to ensure "that the entire healthcare system is readily equipped to identify Veterans at risk for suicide, regardless of where they are receiving care, so they can be connected to life-saving resources and interventions."[6]

Historically, suicide was considered a mental health problem that required intervention by a mental health specialist.[7] However, suicide is now recognized as a "complex problem requiring a full public health approach."[8] Research indicates that 84 percent of individuals who died by

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[1] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) et al., November 23, 2022.

[2] Secretary, "Agency-Wide Required Suicide Prevention Training (VIEWS 3346983)," memorandum to Under Secretaries et al., October 15, 2020; "FY2024-2025 Priority and Goals Department of Veterans Affairs," General Service Administration, accessed June 28, 2024, https://www.performance.gov/agencies/va/apg/fy-24-25/.

[3] VA Office of Mental Health and Suicide Prevention, *2023 National Veteran Suicide Prevention Annual Report*, November 2023; Department of Health and Human Services, *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention.*

[4] "Improving Uptake of the VA Suicide Risk Identification Strategy," VA Quality Enhancement Research Initiative, accessed May 23, 2023, https://www.queri.research.va.gov/qnews/sept20/default.cfm?QnewsMenu=article3.

[5] "Recommended Standard Care for People With Suicide Risk: Making Health Care Suicide Safe," National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group, accessed March 12, 2024, https://theactionalliance.org/sites/default/files/.

[6] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum.

[7] Department of Health and Human Services, *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention.*

[8] VA Office of Mental Health and Suicide Prevention, *2023 National Veteran Suicide Prevention Annual Report*, November 2023.

suicide received healthcare services, mostly in medical specialty and primary care settings, in the year prior to death. Approximately half of those individuals did not have a mental health diagnosis.[9] Therefore, it is critical for clinicians across healthcare settings to screen patients for suicide risk.[10]

## Suicide Risk Identification Strategy

In May 2018, VHA introduced a standardized three-step Suicide Risk Identification Strategy (Risk ID), as "a strategy for standardized, evidence-based screening for the risk of suicide and structured methods for the subsequent evaluation of those who screen positive for risk."[11] From September 2018 through October 2019, VHA further delineated the Risk ID process and implementation timeline and expected full Risk ID implementation by November 17, 2019.[12]

In November 2020, VHA implemented an "enterprise-wide move from a three-step to a two-step process" to align with The Joint Commission standards, clarify expectations, and "increase operational efficiencies to ensure that Veterans obtain necessary consistent care across multiple

[9] Department of Health and Human Services, *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*; Brian K. Ahmedani et al., "Health Care Contacts in the Year Before Suicide Death," *Journal of General Internal Medicine* 29, no. 6 (February 25, 2014): 870-877, https://doi.org/10.1007%2Fs11606-014-2767-3.

[10] Department of Health and Human Services, *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention;* "Risk ID," Veterans Affairs Suicide Risk Identification and Management (Risk ID) SharePoint, https://dvagov.sharepoint.com/sites/ECH/srsa/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FECH%2Fsrsa%2FShared%20Documents%2FRisk%20ID%2FTraining%2FRisk%5FID%5FOverview%2Epdf&parent=%2Fsites%2FECH%2Fsrsa%2FShared%20Documents%2FRisk%20ID%2FTraining. (This site is not publicly accessible.)

[11] Deputy Under Secretary for Health for Operations and Management, "Suicide Risk Screening and Assessment Requirements," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) et al., May 23, 2018.

[12] Deputy Under Secretary for Health for Operations and Management, "Update to Suicide Risk Screening and Assessment Requirements," memorandum to Veterans Integrated Service Network Directors (10N1-23) et al., September 20, 2018; Deputy Under Secretary for Health for Operations and Management (DUSHOM), "Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation," memorandum to Veterans Integrated Service Network Directors (10N1-23) et al., November 2, 2018; Acting Deputy Under Secretary for Health for Operations and Management, "Eliminating Veteran Suicide: Update on Suicide Risk Screening and Evaluation," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) et al., February 22, 2019; Deputy Under Secretary for Health for Operations and Management, "Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and Safety Planning for Emergency Departments (SPED) Initiatives," memorandum to Network Directors (10N1-23) et al., October, 17, 2019.

settings."[13] VHA expected full implementation of the two-step Risk ID process by December 28, 2020 (see figure 1).[14]

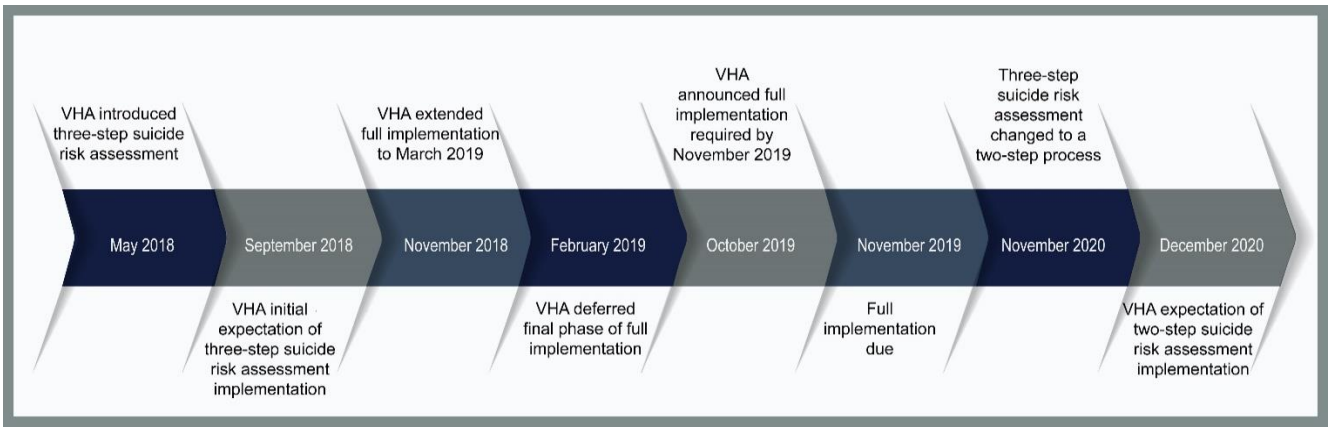


***Figure 1.*** *Risk ID implementation timeline.*
*Source: VHA Risk ID memoranda.*

The two-step Risk ID process requires a standardized suicide risk screening and assessment process using the Columbia-Suicide Severity Rating Scale (screening) and the comprehensive suicide risk evaluation (evaluation) (see figure 2).[15]

[13] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum to Veterans Integrated Service Network Directors (10N1-23) et al., November 13, 2020; The Joint Commission is a non-profit organization that sets standards and evaluates hospitals adherence to these standards to ensure quality health care delivery. "What is Accreditation," The Joint Commission, accessed April 3, 2024, https://www.jointcommission.org/what-we-offer/accreditation/become-accredited/what-is-accreditation/.

[14] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum.

[15] Deputy Under Secretary for Health for Operations and Management, "Suicide Risk Screening and Assessment Requirements," memorandum; Deputy Under Secretary for Health for Operations and Management, "Suicide Risk Screening and Assessment Requirements" memorandum–Attachment B, May 23, 2018. The May 23, 2018, memorandum refers to a comprehensive assessment; however, later memoranda refer to a comprehensive evaluation. This memorandum was in effect during the time frame of the events discussed in this report; it was updated and superseded by Deputy Under Secretary for Health for Operations and Management Memorandum, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum.

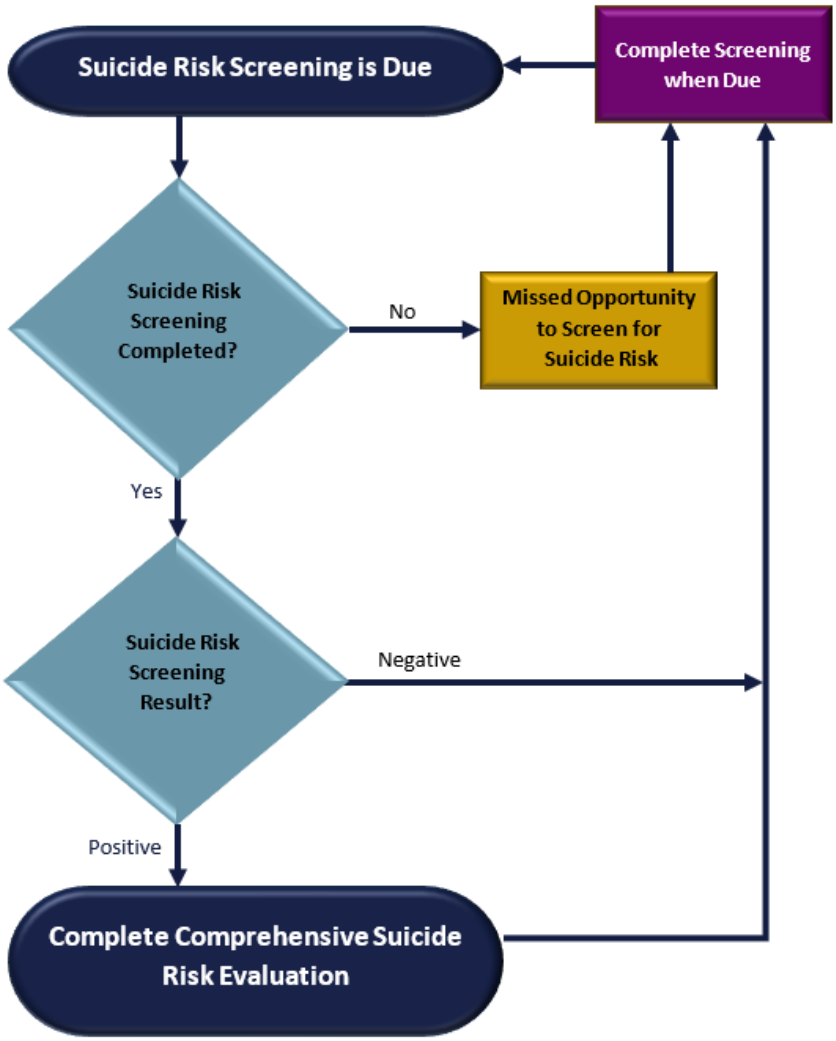


***Figure 2.*** *Annual Risk ID screening process.*
*Source: OIG analysis of VHA documents.*

The screening uses "simple, plain-language questions that anyone can ask" about the patient's past preparatory or suicidal behavior, current intent, and thoughts of a method and plan.[16] A negative screening completes the process; a positive screening requires same-day completion of the suicide risk evaluation.[17] The suicide risk evaluation, which must be completed by a licensed independent provider, includes detailed questions about the patient's suicidal ideation, plan,

[16] "About the Protocol," The Columbia Lighthouse Project, accessed May 28, 2024, https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/.

[17] "Risk ID," Veterans Affairs Suicide Risk Identification and Management (Risk ID) SharePoint; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum. VHA acknowledges that in some clinical circumstances, it may not be feasible to complete the evaluation the same day. In those situations, the evaluation must be completed within 24 hours of a positive screening.

intent, and behaviors; risk and protective factors; and requires the provider to document overall level of suicide risk and establish a risk mitigation plan.[18] The suicide risk evaluation was developed specifically for the veteran population based on evidence-based factors (see figure 3).

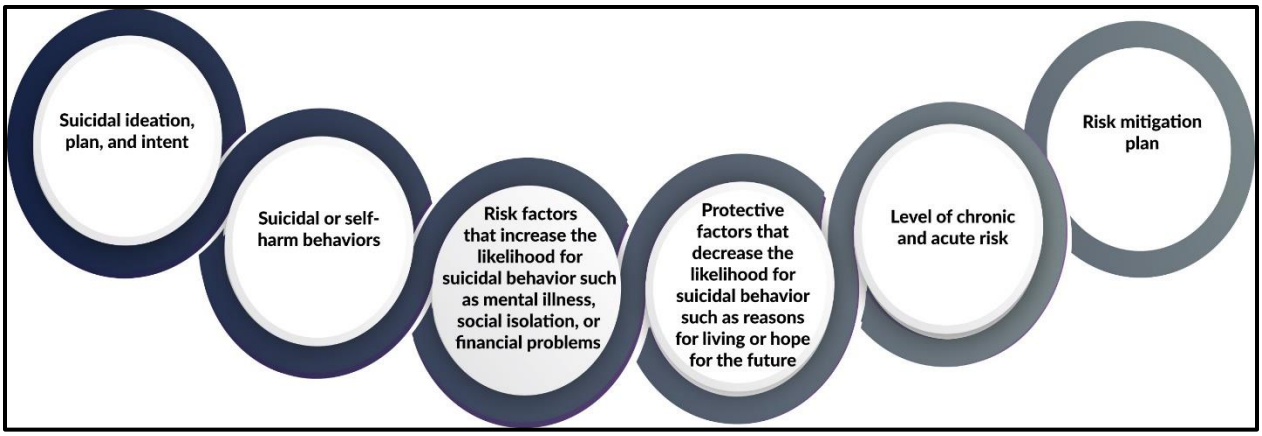


***Figure 3.*** *Evidence-based factors included in the suicide risk evaluation.*
*Source: VA's Suicide Risk Identification Frequently Asked Questions.*

## Prior OIG Reports

From February 5, 2021, through May 1, 2024, the OIG published eight hotline healthcare inspection reports that included one or more recommendations to a facility director or chief of staff related to suicide risk screening or evaluation training, adherence to VHA requirements, or oversight.[19] As of July 16, 2024, all but one of the recommendations has been closed.

[18] "Risk ID," Veterans Affairs Suicide Risk Identification and Management (Risk ID) SharePoint; "Frequently Asked Questions (FAQ)," Veterans Affairs Suicide Risk Identification and Management SharePoint, accessed May 1, 2023, https://dvagov.sharepoint.com/sites/ECH/srsa/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FECH%2Fsrsa%2FShared%20Documents%2FRisk%20ID%2FRisk%20ID%20FAQ%205%2E0%2Epdf&parent=%2Fsites%2FECH%2Fsrsa%2FShared%20Documents%2FRisk%20ID. (This site is not publicly accessible.); VHA Directive 1100.21(1), *Privileging,* March 2, 2023, amended April 23, 2023; A licensed independent practitioner is "an individual permitted by law and the VA medical facility, through its Medical Staff Bylaws to provide patient care services independently, without supervision or direction, within the scope of the individual's license and in accordance with privileges granted by the facility." For the purpose of this report, the OIG refers to a licensed independent practitioner as licensed independent provider.

[19] OIG Hotline "receives, screens, and determines the disposition of complaints concerning veterans or VA that relate to potentially unlawful activity or potential violations of rules or regulations; fraud, waste, and abuse; and gross mismanagement of VA programs and operations." "OIG Hotline," VA OIG, accessed April 8, 2024, https://www.vaoig.gov/hotline/online-forms; The OIG selected this time frame based on the date the inspection was initiated and included three years of inspection reports.

During this same period, the OIG published 44 Comprehensive Healthcare Inspection Program reports that included a total of 44 recommendations related to suicide risk screening or evaluation.[20] As of July 16, 2024, 12 of the 44 recommendations have been closed.

In a November 2022 national review, the OIG recommended the Under Secretary for Health (1) evaluates staff's perceived barriers to Risk ID adherence and takes action as appropriate, and (2) ensures clinicians complete suicide risk evaluations and monitors compliance.[21] The OIG closed both recommendations in January 2024. (See appendix A for published reports.[22])

# Scope and Methodology

The OIG initiated this national review on July 25, 2023, to evaluate VHA's Risk ID screening requirement process, oversight of adherence, and suicide risk training requirements and recommendations across the enterprise. The OIG team reviewed relevant VHA documents, policies, memoranda, and performance metrics related to Risk ID and suicide risk training.

The OIG compiled screening and evaluation metrics for 137 of 139 facilities with data available on the Combined National Suicide Prevention Program Metric Ambulatory Risk ID Power BI Dashboard (Combined Risk ID dashboard) and analyzed trends between and across fiscal years (FYs) 2022 and 2023.[23] Further, the OIG reviewed Rocky Mountain Mental Illness Research,

[20] The OIG Comprehensive Healthcare Inspection Program is "one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years." VA OIG, *Comprehensive Healthcare Inspection of the Columbia VA Health Care System in South Carolina*, Report No. 23-00009-57, January 25, 2024.

[21] VA OIG, *Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearm*, Report No. 21-00175-19, November 17, 2022.

[22] The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

[23] The OIG did not independently verify VHA Combined Risk ID dashboard data for accuracy. A fiscal year is a 12-month cycle that spans October 1 through September 30. Fiscal year 2022 began on October 1, 2021, and ended on September 30, 2022, and fiscal year 2023 began on October 1, 2022, and ended on September 30, 2023; "VA Finance Terms and Definitions," VA/VHA Employee Health Promotion Disease Prevention Guidebook, accessed November 1, 2023, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf; The OIG excluded South Charlotte VA Clinic and Kernersville VA Clinic because the Combined Risk ID dashboard did not include FYs 2022 and 2023 data.

Education, and Clinical Center (MIRECC) for Suicide Prevention annual Risk ID screening and evaluation performance data for 18 clinical service areas for FYs 2022 and 2023.[24]

## Survey Development and Deployment

VHA provided the OIG the names and contact information for Veterans Integrated Service Network (VISN) and facility staff with Risk ID implementation, training, and monitoring responsibilities. The OIG distributed 268 surveys to VHA-identified staff to gain an understanding of their experiences and opinions.[25]

Of the 268 surveys the OIG distributed, 235 were distributed to facility-level staff representing 141 VHA facilities, and 33 to VISN-level staff representing 17 of 18 VISNs.[26]

Of the 235 facility-level staff surveyed, the OIG excluded 16 surveys because the respondent(s)

- incorrectly identified their role (6),
- did not respond to OIG requests to confirm their role (1),
- were out of the office for the time frame for survey completion (2), or
- indicated not being involved in Risk ID implementation, monitoring, or training (7).

Of the 219 surveys, the OIG received 169 (77 percent) completed surveys from facility-level staff, representing 123 VHA facilities; and 31 (94 percent) completed surveys from VISN-level staff, representing 17 VISNs. Staff from 18 facilities did not respond to the survey request (see appendix B).

[24] MIRECC's mission is to decrease veteran suicide risk through innovative prevention strategies, clinical interventions, and increased information sharing and veteran treatment options. "Rocky Mountain MIRECC," VA, accessed March 8, 2024, https://www.mirecc.va.gov/visn19/aboutus/index.asp; The Combined Risk ID dashboard is an application tool that supplies data on adherence to Risk ID ambulatory care requirements. "Overview Risk ID Dashboard," VHA Suicide Risk Identification and Management SharePoint, accessed May 28 2024, https://dvagov.sharepoint.com/:p:/r/sites/ECH/srsa/_layouts/15/Doc.aspx?sourcedoc=%7B75BC663E-62B3-4E2D-B5D1-C94B4FC8BF9E%7D&file=Risk%20ID%20Dashboard%20Overview.pptx&action=edit&mobileredirect=true&DefaultItemOpen=1. (This site is not publicly accessible.) The 18 service areas included Audiology, Chaplin, Center for Integrated Health/Move Weight Management Program for Veterans/Whole Health, Home Based Primary Care, Home Specialty Care, Homeless Program, Medicine Specialty Care, Mental Health, Ophthalmology/Optometry, Palliative Care, Primary Care, Primary Care Mental Health Integration, Rehabilitation and Prosthetic Service, Social Work Service, Surgical Specialty Care, Telephone Ancillary/Case Management, Women's Health Services, and "Other" clinical settings.

[25] The OIG obtained a list of VHA, VISN, and facility-level staff responsible for Risk ID training, implementation, and adherence monitoring.

[26] VHA did not identify a VISN-level staff member with Risk ID implementation, training, and oversight responsibility from VISN 22.

## National Program Office and Facility Interviews

The OIG interviewed Office of Mental Health and Suicide Prevention (OMHSP) and MIRECC leaders and facility-level staff from 21 facilities representing 15 of 18 VISNs. The OIG selected facilities with the lowest and highest suicide screening and evaluation adherence as well as facilities with the greatest adherence increases and decreases between or across FYs 2022 and 2023 (see table 1).

**Table 1. Facility Interview Selection**

| Facility Adherence | Number of Facilities |
|---|---|
| Lowest Screening | 4 |
| Highest Screening | 4 |
| Most Improved Screening | 3 |
| Lowest Evaluation | 4 |
| Highest Evaluation | 6 |
| Most Improved Evaluation | 3 |
| Most Decreased Evaluation | 2 |

***Source:*** *OIG analysis of VHA adherence data from October 2021 through September 2023.*
*Note: Five facilities met the criteria for two categories and were included in each category.*

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

# Inspection Results

The OIG found that the majority of VISN and facility staff with Risk ID responsibilities provided survey and interview responses that reflected a sincere commitment to the role, thoughtful consideration about challenges to fulfilling the role successfully, and enthusiasm about serving in this capacity. VHA requires healthcare providers to complete suicide prevention training. However, the OIG determined that the training does not include Risk ID processes or requirements.[27] In FY 2023, VHA clinical staff failed to complete the required annual suicide risk screening for 40 percent or more of patients at the first encounter in which the screening was due.[28] VHA leaders have conveyed inconsistent expectations to VISN and facility leaders and staff related to annual Risk ID screening expectations. Further, except for emergency departments and urgent care, VHA does not monitor adherence to setting-specific Risk ID requirements. The OIG identified barriers to Risk ID adherence including limited clinical staff engagement, lack of facility leaders' support, performance data limitations, and lack of clarity related to Risk ID responsibilities.

## 1. Risk ID Training

In 2008, VHA introduced suicide risk and intervention training and required all current healthcare providers to complete a one-time training and newly hired providers to complete the training within 90 days of entering employment.[29] As of 2017, VHA additionally required all clinical staff to complete the training annually.[30] Although the training objectives include competency related to suicide risk evaluation, the training content does not include education specific to the Risk ID process and screening and evaluation responsibilities.

A MIRECC leader informed the OIG that in 2019 and 2020, VHA developed trainings about the Risk ID process that included an overview and instructions for suicide risk screening and evaluation. However, VHA does not require the training and does not monitor staff completion of the training. MIRECC leaders told the OIG that information about Risk ID was also available

[27] VHA Directive 2008-051, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, August 28, 2008. This directive was rescinded and replaced by VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022.

[28] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum.

[29] VHA Directive 2008-051, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, August 28, 2008. This directive was rescinded and replaced by VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022. A healthcare provider was defined as a "full-time, part-time, or intermittent employee engaged in patient care as a Physician, Psychologist, Registered Nurse, Social Worker, Physician Assistant, Pharmacists, and Dentist, as well as any employee serving in the capacity of Case Manager or Vet Center Team Leader and Counselor."

[30] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017.

through weekly technical assistance calls and instructional materials on the Risk ID SharePoint site.[31]

In response to Comprehensive Healthcare Inspection Program reports published from February 5, 2021, through May 1, 2024, facility leaders attributed more than half of the identified Risk ID deficiencies to staff's lack of awareness of Risk ID requirements.[32] Facility leaders also identified staffing challenges and lack of a handoff process to complete an evaluation in response to a positive screening as reasons for Risk ID deficiencies (see figure 4).

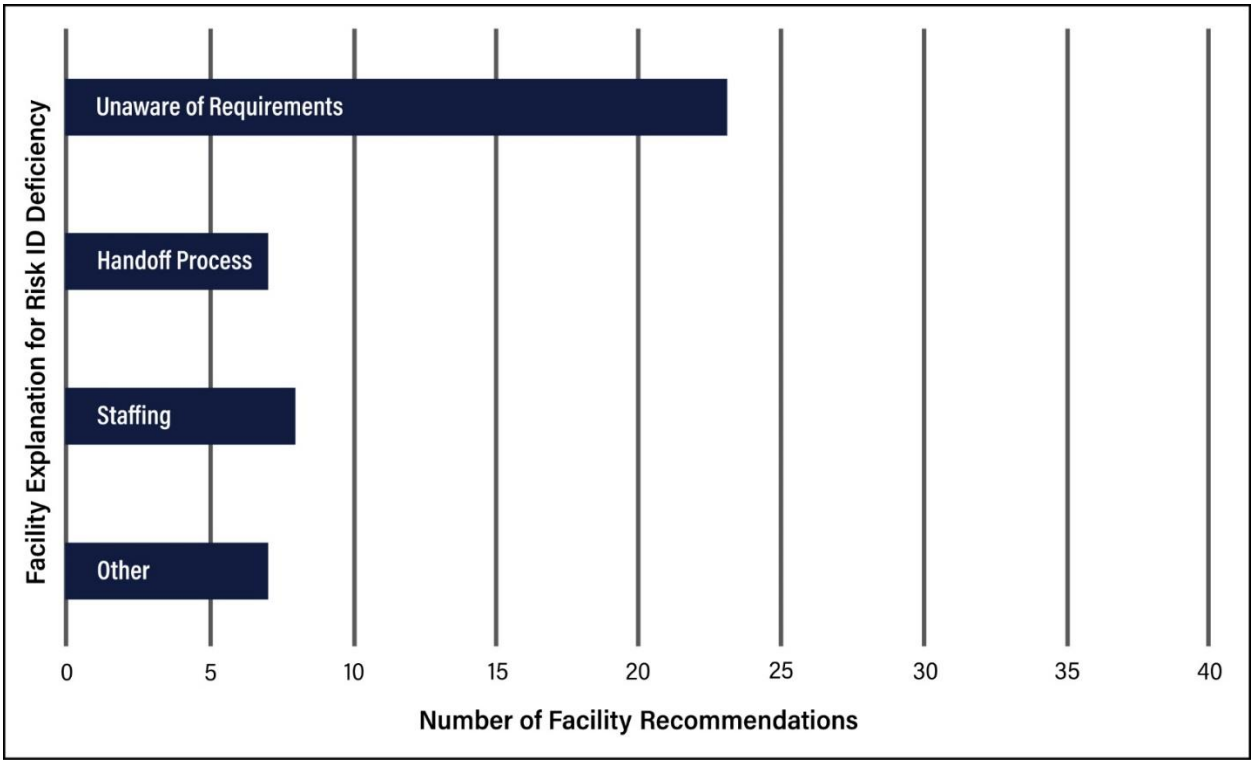


***Figure 4.*** *Barriers to fulfilling Risk ID responsibilities.*
*Source: OIG analysis of survey results.*
*Note: Other explanations for deficiencies included complexity of evaluation, ineffective processes, documentation errors, and competing priorities.*

Although VHA requires healthcare providers to complete suicide prevention training, the OIG determined that the training does not address Risk ID processes or requirements.[33] The OIG

[31] VA SharePoint sites are created by VA staff and available to VHA system users to provide information and exchange ideas.

[32] The published Comprehensive Healthcare Inspection Program reports included electronic health records from December 2019 through September 2022.

[33] VHA Directive 2008-051, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, August 28, 2008. This directive was rescinded and replaced by VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022; VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017.

would expect required suicide risk assessment and intervention training to provide information related to Risk ID screening and evaluation responsibilities. Inadequate knowledge of Risk ID requirements contributes to decreased adherence to suicide risk screening and evaluation, which may result in underestimation of patients' suicide risk and ultimately a failure to facilitate risk mitigation.

## 2. Annual Risk ID Adherence and Oversight

VHA requires annual screening for all VHA patients and established an annual screening clinical reminder (clinical reminder) in patients' electronic health records (EHRs) that alerts staff to conduct the annual screening.[34] VHA stated that "facilities are expected to complete 100% of required" screenings and evaluations.[35] Additionally, annual screening must be completed during the first encounter after the clinical reminder is due.[36]

OMHSP provides monthly national-, VISN-, and facility-level annual Risk ID screening performance data on the Combined Risk ID dashboard, which is accessible to all VHA staff.[37] The Combined Risk ID dashboard includes two metrics that measure adherence to annual suicide risk screening and evaluation requirements.[38] The eCSSRS1 (screening metric) calculates "[percent] of outpatient encounters that were due for suicide risk screening, within a given facility, with a same day C-SSRS [screening], CSRE [evaluation], or attempted suicide risk screening." The eCSRE1 (evaluation metric) calculates the "[percent] of patients with timely completion of the [evaluation] following a positive [screening] that satisfied the annual suicide risk screen[ing] reminder."

OMHSP leaders told the OIG that Risk ID adherence responsibilities are defined in operational memoranda, which are "guidance documents that establish a course of action consistent with VHA national policy" and VISN and facility leaders "have flexibility within the parameters of

[34] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum. The universal screening requirement is facilitated though the clinical reminder system using the Columbia-Suicide Severity Rating Scale (screening). A clinical reminder is an EHR tool that alerts providers to clinical interventions due. "VistA Clinical Reminders Version 2.0," VA Software Document Library, October 24, 2006, updated September 14, 2021.

[35] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum.

[36] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum. VHA acknowledges that, in some clinical circumstances, it may not be feasible to complete the evaluation the same day. In those situations, the evaluation must be completed within 24 hours of a positive screening.

[37] As of April 2024, the Combined Risk ID dashboard does not include VHA sites using the new EHR.

[38] "Risk ID Metrics Fact Sheet," VA Suicide Risk Identification and Management (Risk ID) SharePoint, accessed February 28, 2024, https://dvagov.sharepoint.com/sites/ECH/srsa/. (This site is not publicly accessible.)

the memorandum[s] for determining needed steps for implementation, including responsible parties."

In FY 2023, the national screening metric indicated 55 percent adherence and did not exceed 60 percent in any given month. VHA clinical staff failed to complete the required annual screening for 40 percent or more of patients at the first encounter in which the screening was due.

OMHSP and MIRECC leaders told the OIG that the screening metric is a measurement of the completion of the annual screening at the first encounter when the screening is due (timely completion) and does not reflect screening completed at a later encounter. One MIRECC leader told the OIG "it's not a look back of . . . how many veterans has the VA seen in the last year and how many have gotten a screen . . . in the last year. This is . . . really focused on a . . . specific . . . subgroup of those who have had an encounter or have had a screen due during that encounter." Another MIRECC leader stated, "It is a much more precise . . . and I think much harder to achieve measure."

In interviews with the OIG, MIRECC leaders reported adopting the screening metric as a process improvement measure "to increase adoption of suicide risk screening enterprise wide" and recognized that suicide risk screening across all services was "a really big ask and it's a really big culture change." They indicated that the screening metric provides information about whether clinicians across service lines are completing the annual screening at the earliest opportunity when the screening is due.

Facility staff told the OIG that lower adherence to the screening metric is seen in clinical areas that do not typically complete clinical reminders (see figure 5).

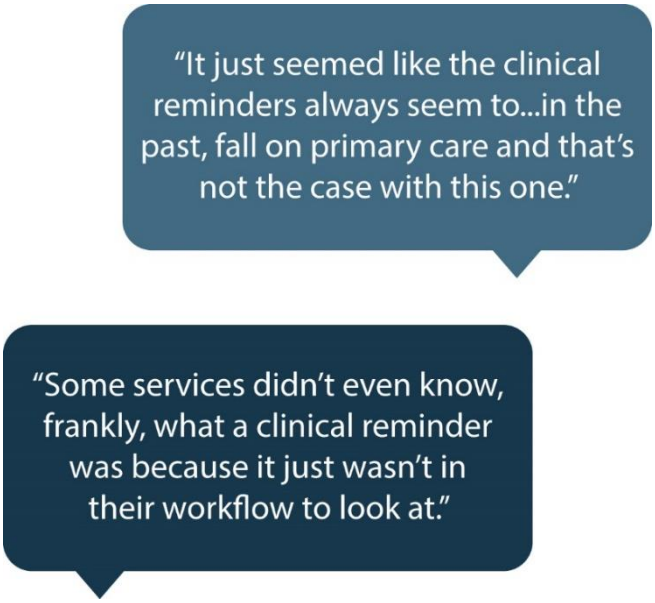


***Figure 5.*** *Facility interview comments on screening clinical reminder.*
*Source: Facility interviews.*

Nationally, the FY 2023 clinic screening metric adherence ranged from 6 to 82 percent. Primary Care and Women's Health demonstrated the highest adherence while Chaplain and Palliative and Hospice had the lowest adherence (see figure 6).

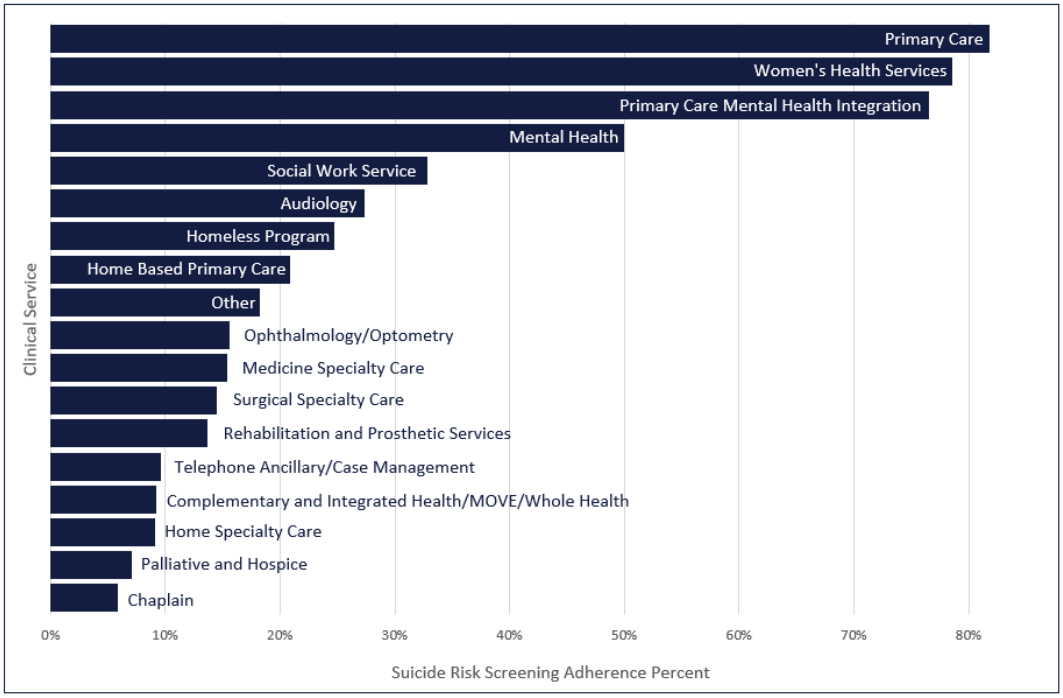


***Figure 6.*** *FY 2023 Timely annual screening adherence by clinical area.*
*Source: OIG analysis of VHA data.*

The same year, VHA demonstrated 82 percent adherence to same-day completion of an evaluation in response to a positive screening, and facility-level adherence ranged from 56 to 100 percent. Although VHA demonstrated greater adherence to the evaluation than the screening metric, the OIG determined that the evaluation metric conveys limited information because it does not include patients VHA clinical staff failed to screen (see figure 7).

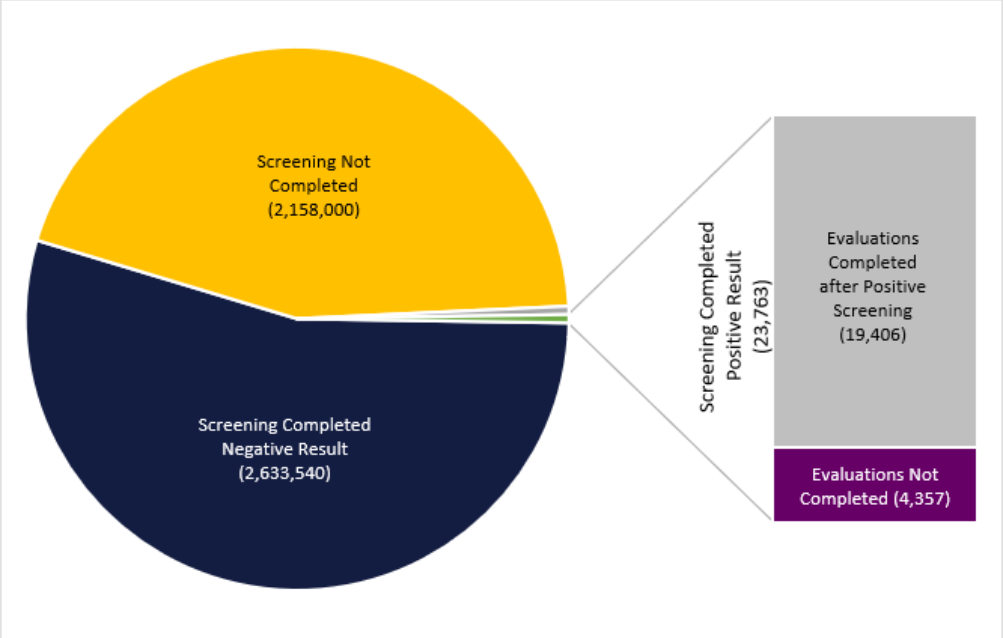


***Figure 7.*** *FY 2023 timely annual screening and evaluation.*
*Source: OIG analysis of VHA data.*

OMHSP leaders acknowledged that annual screening and evaluation adherence was below the expected 100 percent. An OMHSP leader stated, "clinically we would hope that we strive to as close as 100 percent as possible." The leader also acknowledged "we have to strike a little bit of a . . . balance and be careful to . . . not set benchmarks that are completely unachievable given the place that we're at in [Risk ID] implementation." Another OMHSP leader told the OIG that "if we came right out of the gate with something strong, that would be very hard for them to meet. So, we need to allow them time to develop an implementation process." OMHSP leaders explained that facilities need time to implement the standardized processes, which are unique for each facility, based on staffing, operations, and the flow of care.

A MIRECC leader reported that adherence is increasing for both metrics and acknowledged that "some sites are increasing faster" than other sites. The OIG found that national screening adherence increased from 46 to 55 percent from FY 2022 to FY 2023. However, the facility with the greatest improvement increased screening adherence to 64 percent, which is greater than the national average but below the expectation of 100 percent. Further, during the same time frame, three facilities decreased in screening adherence and 15 facilities decreased in evaluation adherence. In interviews with the OIG, facility staff identified multiple factors, which contributed to variability in adherence (see figure 8).


***Figure 8.*** *Facility-identified factors that contribute to adherence.*
*Source: OIG analysis of facility staff interviews.*

OMHSP and MIRECC leaders reported that VHA has not established Risk ID screening and evaluation performance benchmarks.[39] The OIG determined that VHA has conveyed inconsistent expectations to VISN and facility leaders and staff (see figure 9).

[39] A benchmark is "a point of reference from which measurements may be made," and sets a higher standard "than comparing to any average." *Merriam-Webster.com Dictionary,* "benchmark," accessed April 29, 2024, https://www.merriam-webster.com/dictionary/benchmark; "Comparing Quality Scores to a Benchmark," Agency for Healthcare Research and Quality, accessed April 29, 2024, https://www.ahrq.gov/talkingquality/translate/compare/choose/benchmark.html#:~:text=Comparing%20performance%20to%20a%20benchmark,in%20the%20State%20or%20Nation.

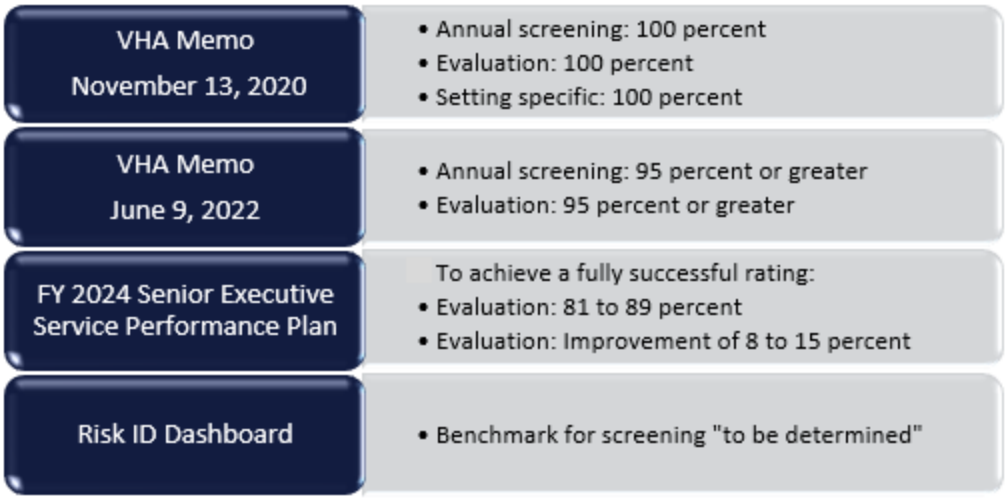


***Figure 9.*** *VHA Risk ID screening and evaluation benchmarks.*
*Source: VHA memoranda, FY 2024 Senior Executive Service Performance Plan, and Combined Risk ID dashboard.*
*Note: The Senior Executive Service Performance Plan, applicable to network and facility directors, communicates VA's expectations to achieve fully successful or higher performance ratings; the improvement range of 8 to 15 percent is based on VISN or facility baseline performance.*

A MIRECC leader reported that in January 2023, VISN and facility leaders began receiving Risk ID screening and evaluation adherence data monthly, including facility-level performance relative to the national average. However, given the 55 percent national Risk ID screening adherence in FY 2023, the OIG would expect VHA to establish performance benchmarks, which reflect the importance of suicide risk screening.

Despite the lack of established Risk ID national benchmarks, nearly all facility survey respondents with Risk ID responsibilities reported monitoring suicide risk screening (95 percent) and evaluation (92 percent) adherence. Further, over 80 percent of respondents reported reviewing the Combined Risk ID dashboard at least weekly and over 90 percent reported the Combined Risk ID dashboard data was helpful in fulfilling Risk ID responsibilities. Although over 70 percent of facility-level staff interviewed indicated having established benchmarks, the OIG determined that facility-level benchmarks varied (see table 2). While some facility-level benchmarks were based on the national average, others were based on criteria such as OMHSP or VISN guidance, the network and medical center directors' performance plan, or attainable incremental improvement. Identified facility-level benchmarks ranged from 59 to 95 percent for screening and 90 to 100 percent for evaluation.

**Table 2. Facility-Level Screening and Evaluation Benchmarks**

| Identified Benchmark | Screening (N=21) | Evaluation (N=21) |
|---|---|---|
| Facility-Specific | 12 | 13 |
| National Average | 3 | 3 |
| None | 6 | 5 |

*Source: OIG analysis of interview responses.*

## 3. Setting-Specific Risk ID Adherence and Oversight

VHA recognized the need for suicide risk screening beyond annual screening with the implementation of setting-specific Risk ID requirements (see figure 10). Specifically, VHA required a screening at each emergency department and urgent care encounter; upon intake in outpatient mental health, opioid treatment, sleep, and pain clinics; and within 24-hours of admission and prior to discharge from mental health residential rehabilitation treatment programs, community living centers, inpatient mental health, inpatient medical and surgical, and inpatient rehabilitation settings. Regardless of clinical setting, a licensed independent provider must complete an evaluation in response to, and on the same day as, a positive screening.[40]

[40] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum. When it is not clinically or logistically feasible to complete an evaluation on the same day as a positive screening, the evaluation must be completed within 24 hours after establishing the safety of the patient.

| Setting | Each Encounter | At Intake | Within 24 hours of Admission | Within 24 hours prior to Discharge |
|---|---|---|---|---|
| Emergency Department and Urgent Care | ✓ | | | |
| Outpatient Mental Health | | ✓ | | |
| Opioid Treatment Program | | ✓ | | |
| Sleep Clinic | | ✓* | | |
| Pain Clinic | | ✓* | | |
| Mental Health Residential Rehabilitation Treatment Program | | | ✓ | ✓ |
| Community Living Center | | | ✓ | ✓ |
| Inpatient Mental Health | | | ✓ | ✓ |
| Inpatient Medical and Surgical | | | ✓ | ✓ |
| Inpatient Rehabilitation | | | ✓ | ✓ |

***Figure 10.*** *Setting-specific Risk ID requirements.*
*Source: VHA setting-specific Risk ID minimum requirements.*
**The screening is not required at intake if one was completed within the prior 30 days.*

With the 2018 introduction of Risk ID, VHA encouraged facility leaders to "develop internal standard operating procedures to support implementation across these different care settings," and stated that "detailed information will be provided as metric specifications are finalized."[41] However, the OIG determined that VHA did not establish metrics to measure adherence to setting-specific Risk ID requirements except for emergency departments and urgent care.

Since April 2021, OMHSP has monitored adherence to same-day evaluation in response to a positive suicide risk screening in emergency departments and urgent care and established a

[41] Deputy Under Secretary for Health for Operations and Management, "Suicide Risk Screening and Assessment Requirements," memorandum.

benchmark of 90 percent.[42] Nationally, VHA adherence to timely evaluation met or exceeded the 90 percent benchmark in FYs 2022 and 2023. In October 2023, VHA initiated monitoring of suicide risk screening adherence at every emergency department and urgent care encounter. From October 1, 2023, through March 31, 2024, VHA demonstrated greater than 98 percent adherence.

The OIG determined, however, that VHA did not monitor adherence to setting-specific Risk ID requirements in outpatient mental health clinics, opioid treatment programs, sleep and pain clinics, mental health residential rehabilitation treatment programs, community living centers, or inpatient mental health, medical and surgical, and rehabilitation settings. In a December 18, 2024, national review, the OIG found that inpatient mental health unit staff failed to document a completed suicide risk screening within 24 hours before discharge, as required, for 24 percent of 200 patient discharges from October 1, 2019, through September 30, 2020.[43]

VHA provides performance metrics that allow facility leaders and staff to monitor Risk ID screening and evaluation and emergency department and urgent care Risk ID adherence. However, the OIG determined that VHA did not establish performance benchmarks or setting-specific requirement monitors (except for emergency departments and urgent care). The absence of defined performance expectations and oversight may contribute to inadequate suicide risk screening, which ultimately results in a failure to identify patients at risk for suicide and opportunities for risk mitigation.

## 4. Barriers to Adherence

Most survey respondents (76 percent) reported barriers to fulfilling Risk ID responsibilities. Survey respondents most frequently referenced limited engagement of facility clinical staff and lack of facility leaders' support as barriers. Based on survey responses and staff interviews, the OIG determined that performance data limitations and the shared responsibility for addressing Risk ID deficiencies has contributed to a lack of clarity related to accountability for Risk ID adherence monitoring and performance improvement.

### Clinical Staff Engagement

During interviews, OMHSP and MIRECC leaders acknowledged the importance of engaging staff in clinics other than mental health. An OMHSP leader told the OIG,

[42] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum. VHA acknowledges that, in some clinical circumstances, it may not be feasible to complete the evaluation the same day. In those situations, the evaluation must be completed within 24 hours of a positive screening.

[43] VA OIG, *Deficiencies in Inpatient Mental Health Suicide Risk Assessment, Mental Health Treatment Coordinator Processes, and Discharge Care Coordination*, Report No. 21-02389-23, December 18, 2024.

> only a certain percentage of veterans are coming through mental health . . . that's where we, that's kind of where we start, is setting the expectation, trying to help . . . build partnerships with . . . medical specialties to . . . help them embed Risk ID into their workflow and do the training that they need to continue to drive performance overall, holistically, and not just in mental health settings.

Additionally, an OMHSP leader noted that non-mental health staff may be hesitant to screen patients due to discomfort about what to do if the screening is positive. The leader stated,

> that means that now [staff are] going to have to respond to that risk and develop a process to make sure that veteran is being evaluated and makes it on to the next phase of the Risk ID process.

More than half of facility staff interviewed shared that staff perceive Risk ID as a responsibility of suicide prevention program staff.

In an interview with the OIG, one facility staff member stated,

> I think . . . just the broader issue of comfort around suicide . . . continues to be a struggle for healthcare providers across disciplines . . . it's a challenge to get folks to have that comfort level when many of those medical providers have never had any training in talking or thinking about it.

A MIRECC leader reported a perception that staff demonstrate increased engagement when provided education that patients who die by suicide are "way more likely to be seen outside of mental health."

During a March 2022 technical assistance call, MIRECC staff recommended the development of service-level standard operating procedures to delineate a process to complete an in-person or telephone transfer of care to a licensed independent provider for same-day evaluation in response to a patient's positive screening.[44] However, fewer than half of facility staff interviewed reported implementing service-level standard operating procedures.

MIRECC leaders reported providing education and support to clinical specialty areas when leaders in those areas sought consultation. However, the OIG determined that VHA lacked a standardized and monitored strategy to ensure non-mental health clinical specialty leaders and staff are aware of and adherent to the Risk ID screening and evaluation requirements.

[44] "Risk ID and SPED Technical Assistance Call: March 24, 2022," Veterans Affairs Suicide Risk Identification and Management (Risk ID) SharePoint, February 15, 2024, https://dvagov.sharepoint.com/:p:/r/sites/ECH/srsa/_layouts/15/. (This site is not publicly accessible.)

## Facility Leaders' Support

In interviews with the OIG, 16 facility staff described the importance of leaders' support in Risk ID implementation and adherence.[45] One facility staff member told the OIG,

> Our Chief of Staff and our Director and [executive leadership team] all are very supportive of suicide prevention, broadly speaking but that includes Risk ID. That's why it's a strategic initiative . . . [facility-wide]. And because of that support, there's an expectation . . . explicitly from the Chief of Staff and our Chief of Patient Care Services . . . for service chiefs across our clinical service areas . . . to make sure we're doing what we need to do for Risk ID implementation.

An OMHSP leader also acknowledged the importance of engaging VISN and facility leaders in supporting Risk ID implementation and adherence. OMHSP leaders reported that in FY 2024, VHA added the Risk ID evaluation metric to the network and facility directors' performance plan to communicate minimum expectations for performance of network and medical center directors to ensure suicide risk evaluations are completed. An OMHSP leader told the OIG that the addition of the Risk ID evaluation metric to the Senior Executive Service Performance Plan established clearer standards and "engages the uppermost levels of leadership in terms of setting expectations for performance . . . to drive performance."

## Performance Data Limitations

Facility staff at 8 of 21 facilities reported limitations to monitoring Risk ID adherence due to an inability to access patient- or provider-level data. VHA provides an evaluation adherence report, which allows facility staff to view the number of missed screenings within a clinical service but does not provide patient identifying information or the name of the provider who did not complete the required screening.[46] An OMHSP leader explained that national reports are intended to promote proactive identification of patients with a screening due at a future appointment that builds "a culture around suicide risk identification" as opposed to creating a "reactive culture" focused on metric performance. However, facility staff told the OIG that without identifying patient and provider information, it is difficult to adequately address annual screening deficiencies, target education, and ensure provider accountability for completing required screening. A staff member at one facility reported,

> I understand the rationale . . . that they provide and wanting it to be something that we focus on with the process, not . . . punitive against a staff member, but it does get hard

[45] The 16 facility staff described, unsolicited, the importance of leaders' support.

[46] "Universal Suicide Screening: Making Suicide Prevention Everyone's Business," VA Suicide Risk Identification and Management (Risk ID) SharePoint; Risk ID Dashboard, Power BI, https://app.powerbigov.us/groups/me/apps/ab54d698 -45d6-4758-a5a4-fc96bf48cbd2/reports/d9d396c9-fc57-42fc-9d23-80f44d7cd4c6/ReportSectioncba7e1822e275c989133?ctid=e95f1b23-abaf-45ee-821d-b7ab251ab3bf. (This site is not publicly accessible.)

> when . . . it's a high-volume shared clinic . . . location to know where to provide that additional support and education.

In interviews with the OIG, facility staff also described spending significant time conducting additional tasks such as chart reviews to identify patient and provider information to provide oversight related to the evaluation adherence report and improve Risk ID adherence.

The OIG determined that limited facility clinical staff engagement, lack of facility leader support, and limitations of performance data may create barriers to Risk ID adherence and oversight. These identified issues are consistent with the Under Secretary for Health's response to the November 2022 OIG recommendation for evaluation of barriers to the completion of Risk ID requirements.[47] VHA identified the following barriers:

- Clinical specialty staff were not accustomed to completing clinical reminders
- Clinical specialty staff needed additional training in suicide risk and evaluation
- Clinical areas may require additional implementation support
- Limited knowledge and buy-in of facility leaders

VHA leaders' actions included providing training resources and updated reports and sharing of facility staff-identified practices to overcome the identified barriers.

## Delineation of Responsibilities

VHA informed the OIG that,

> The Office of Mental Health and Suicide Prevention, Suicide Prevention Program, in conjunction with the Rocky Mountain Mental Illness Research Education and Clinical Center (MIRECC) for Suicide Prevention, are responsible for monitoring Risk ID implementation and providing feedback to facilities through VISN Chief Mental Health Officers.

An OMHSP leader informed the OIG that Risk ID memoranda typically identify, "the Under Secretary as the delegating authority," and "then it rolls down to the [MIRECC and OMHSP] executive leadership." The leader also clarified that, "whenever we do performance monitoring and communicate metrics . . . and performance to the facilities or to the VISNs, especially when we are . . . providing assistance to lower performing facilities, we do that . . . jointly with [MIRECC]." However, the OMHSP also stated that MIRECC typically does not "roll anything out . . . without our . . . approval because . . . as subject matter experts, they may support the content, but they do rely on us . . . for the final approval."

[47] VA OIG, *Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearm*, Report No. 21-00175-19, November 17, 2022.

A MIRECC leader told the OIG that "the policies are OMHSP's" and MIRECC has a role in Risk ID monitoring but does not have the authority to establish policies or ensure Risk ID implementation. The MIRECC leader told the OIG, "I just want to be really clear about that . . . the leadership at each facility, really, ultimately has responsibility for making sure [Risk ID is] implemented."

The OIG concluded that the shared responsibility for addressing Risk ID deficiencies has contributed to a lack of clarity related to accountability for Risk ID adherence monitoring and performance improvement. The OIG would expect a clearly delineated process for reporting adherence and identification of individuals responsible for addressing deficiencies. The absence of clear processes and responsible individuals has resulted in failure to identify patients potentially at risk for suicide and provide critical risk mitigation.

The OIG recognizes that the national implementation of annual suicide risk screening required significant cultural and procedural changes for clinical services not typically responsible for such screening and follow-up requirements; however, the OIG would expect wider distribution of the information throughout the enterprise with clear accountability for the required actions, technical proficiency, leadership engagement, and monitoring.

# Conclusion

The VA OIG conducted a national review to evaluate suicide risk screening and evaluation training, adherence, and oversight procedures.

VHA requires healthcare providers to complete suicide risk and intervention training; however, the training does not address Risk ID processes or requirements. The OIG would expect required suicide risk assessment and intervention training to provide information related to Risk ID screening and evaluation responsibilities. Inadequate knowledge of Risk ID requirements may contribute to decreased adherence to suicide risk screening and evaluation, underestimation of patients' suicide risk, and ultimately a failure to facilitate risk mitigation.

VHA has not established Risk ID screening and evaluation performance benchmarks and has conveyed inconsistent expectations to VISN and facility leaders and staff. In FY 2023, VHA demonstrated 55 percent screening and 82 percent evaluation adherence. Although VHA demonstrated greater adherence to the evaluation than the screening metric, the OIG determined that the evaluation metric conveys limited information because it does not include patients VHA clinical staff failed to screen.

VHA also did not establish metrics to measure adherence to setting-specific Risk ID requirements except for emergency departments and urgent care. The OIG would expect clear benchmarks for suicide risk screening and evaluation that reflect the clinical importance of suicide risk identification requirements. The absence of defined performance expectations and oversight may contribute to inadequate suicide risk screening, which ultimately results in a failure to identify patients at risk for suicide and opportunities for risk mitigation.

Based on survey responses and interviews, the OIG identified several barriers to staff fulfilling Risk ID oversight responsibilities, including (1) limited engagement of facility clinical staff, (2) lack of facility leaders' support, (3) limitations of performance data, and (4) unclear delineation of responsibilities. VHA lacked a standardized and monitored strategy to ensure clinical specialty leaders and staff are aware of and adherent to the Risk ID screening and evaluation requirements. OMHSP leaders acknowledged the importance of engaging leaders in Risk ID implementation and, in FY 2024, VHA added a Risk ID evaluation metric to the network and facility directors' performance plan to engage "the uppermost levels of leadership in terms of setting expectations for performance . . . to drive performance."

VHA provides an evaluation adherence report, which allows facility staff to view the number of missed screenings within a clinical service. However, facility staff told the OIG that without identifying patient and provider information, it is difficult to adequately address annual screening deficiencies, target education, and ensure provider accountability for completing required screening.

VHA informed the OIG that OMHSP, "in conjunction with" the MIRECC, "are responsible for monitoring Risk ID implementation and providing feedback to facilities through VISN Chief Mental Health Officers." The OIG concluded that the shared responsibility for addressing Risk ID deficiencies has contributed to a lack of clarity related to accountability for Risk ID adherence monitoring and performance improvement. The absence of clear processes and responsible individuals has resulted in failure to identify patients potentially at risk for suicide and provide critical risk mitigation.

The OIG made six recommendations to the Under Secretary for Health.

# Recommendations 1–6

1. The Under Secretary for Health ensures that required suicide risk and intervention training includes suicide risk identification screening and evaluation requirements, procedures, and instruction.

2. The Under Secretary for Health considers establishing benchmarks for suicide risk screening and evaluation that reflect the clinical importance of suicide risk identification requirements and takes action as warranted.

3. The Under Secretary for Health ensures monitoring of adherence to suicide risk identification screening and evaluation setting-specific requirements.

4. The Under Secretary for Health ensures actions taken to address barriers to completing suicide risk screening and evaluation are effective to increase adherence to annual and setting-specific requirements in all clinical settings.

5. The Under Secretary for Health ensures non-mental health clinical specialty leaders are aware of and adherent to the suicide risk identification screening and evaluation requirements.

6. The Under Secretary for Health ensures clearly identified responsibilities for suicide risk identification screening and evaluation adherence monitoring and oversight.

# Appendix A: Prior OIG Reports

| | Published Healthcare Inspection Reports | Publication Date |
|---|---|---|
| 1. | Comprehensive Healthcare Inspection of the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri | May 1, 2024 |
| 2. | Comprehensive Healthcare Inspection of VA Finger Lakes Healthcare System in Bath, New York | April 30, 2024 |
| 3. | Comprehensive Healthcare Inspection of the Kansas City VA Medical Center in Missouri | April 25, 2024 |
| 4. | Comprehensive Healthcare Inspection of the VA Illiana Health Care System in Danville, Illinois | April 24,2024 |
| 5. | Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia | April 23, 2024 |
| 6. | Comprehensive Healthcare Inspection of the Edward Hines, Jr. VA Hospital in Hines, Illinois | April 17, 2024 |
| 7. | Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center in Chicago, Illinois | April 17, 2024 |
| 8. | Comprehensive Healthcare Inspection of the Boise VA Medical Center in Idaho | April 16, 2024 |
| 9. | Comprehensive Healthcare Inspection of the VA Bedford Healthcare System in Massachusetts | April 11, 2024 |
| 10. | Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah | April 10, 2024 |
| 11. | Comprehensive Healthcare Inspection of the Syracuse VA Medical Center in New York | April 9, 2024 |
| 12. | Comprehensive Healthcare Inspection of the VA Northern Indiana Health Care System in Marion | April 4, 2024 |
| 13. | Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta | April 3, 2024 |
| 14. | Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan | April 3, 2024 |
| 15. | Comprehensive Healthcare Inspection of the VA Central Iowa Health Care System in Des Moines | April 2, 2024 |
| 16. | Comprehensive Healthcare Inspection of the VA Black Hills Health Care System in Fort Meade, South Dakota | March 26, 2024 |
| 17. | Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center in Wyoming | March 26, 2024 |
| 18. | Comprehensive Healthcare Inspection of the VA Ann Arbor Healthcare System in Michigan | March 26, 2024 |
| 19. | Comprehensive Healthcare Inspection of the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin | March 25, 2024 |
| 20. | Comprehensive Healthcare Inspection of the Beckley VA Medical Center in West Virginia | March 19, 2024 |

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| 21. | Comprehensive Healthcare Inspection of Central Alabama Veterans Health Care System in Montgomery | March 12, 2024 |
| 22. | Comprehensive Healthcare Inspection of the Charles George VA Medical Center in Asheville, North Carolina | March 7, 2024 |
| 23. | Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire | March 6, 2024 |
| 24. | Comprehensive Healthcare Inspection of the Aleda E. Lutz VA Medical Center in Saginaw, Michigan | February 29, 2024 |
| 25. | Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont | February 28, 2024 |
| 26. | Comprehensive Healthcare Inspection of the Minneapolis VA Health Care System in Minnesota | February 27, 2024 |
| 27. | Comprehensive Healthcare Inspection of the Alaska VA Healthcare System in Anchorage | February 22, 2024 |
| 28. | Comprehensive Healthcare Inspection of the Battle Creek VA Medical Center in Michigan | February 20, 2024 |
| 29. | Comprehensive Healthcare Inspection of the Samuel S. Stratton VA Medical Center in Albany, New York | February 13, 2024 |
| 30. | Comprehensive Healthcare Inspection of the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin | February 8, 2024 |
| 31. | Comprehensive Healthcare Inspection of the Columbia VA Health Care System in South Carolina | January 25, 2024 |
| 32. | Comprehensive Healthcare Inspection of the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana | January 3, 2024 |
| 33. | Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina | December 19, 2023 |
| 34. | Comprehensive Healthcare Inspection of the VA Providence Healthcare System in Rhode Island | December 5, 2023 |
| 35. | Comprehensive Healthcare Inspection of the Overton Brooks VA Medical Center in Shreveport, Louisiana | November 15, 2023 |
| 36. | Comprehensive Healthcare Inspection of the Alexandria VA Health Care System in Pineville, Louisiana | September 29, 2023 |
| 37. | Comprehensive Healthcare Inspection of the Central Arkansas Veterans Healthcare System in Little Rock | September 29, 2023 |
| 38. | Comprehensive Healthcare Inspection of the Wilkes-Barre VA Medical Center in Pennsylvania | September 19, 2023 |
| 39. | Comprehensive Healthcare Inspection of the Erie VA Medical Center in Pennsylvania | September 13, 2023 |
| 40. | Comprehensive Healthcare Inspection of the VA NY Harbor Healthcare System in New York | August 1, 2023 |
| 41. | Comprehensive Healthcare Inspection of the VA Central California Health Care System in Fresno | July 20, 2023 |

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| 42. | Comprehensive Healthcare Inspection of the Manila VA Clinic in Pasay City, Philippines | June 8, 2023 |
| 43. | Comprehensive Healthcare Inspection of the Lexington VA Health Care System in Kentucky | December 13, 2022 |
| 44. | Comprehensive Healthcare Inspection of the VA Boston Healthcare System in Massachusetts | September 24, 2021 |
| 45. | Deficiencies in Quality of Care at the VA Maine Healthcare System in Augusta | March 12, 2024 |
| 46. | Deficiencies in Emergency Department Care for a Patient Who Died by Suicide at the John Cochran Division of the VA St. Louis Health Care System in Missouri | June 29, 2023 |
| 47. | Deficient Care of a Patient Who Died by Suicide and Facility Leaders' Response at the Charlie Norwood VA Medical Center in Augusta, Georgia | May 10, 2023 |
| 48. | Inadequate Outpatient Mental Health Triage and Care of a Patient at the Chico Community-Based Outpatient Clinic in California | February 2, 2023 |
| 49. | Deficiencies in a Behavioral Health Provider's Documentation and Assessments, and Oversight of Nurse Practitioners at the VA Pittsburgh Healthcare System in Pennsylvania | May 3, 2022 |
| 50. | Deficiencies in Mental Health Care Coordination and Administrative Processes for a Patient Who Died by Suicide, Ralph H. Johnson VA Medical Center in Charleston, South Carolina | August 3, 2021 |
| 51. | Deficiencies in the Mental Health Care of a Patient Who Died by Suicide and Failure to Complete an Institutional Disclosure, VA Southern Nevada Healthcare System in Las Vegas | July 15, 2021 |
| 52. | Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona | March 23, 2021 |
| 53. | Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearm | November 17, 2022 |

*Source: OIG analysis of prior OIG publications to identify Risk ID-related recommendations.*

# Appendix B: VHA Facilities with No Survey Response

| Facility Name | Location |
|---|---|
| Samuel S. Stratton VAMC | Albany, New York |
| Thomas E. Creek VAMC | Amarillo, Texas |
| Charlie Norwood VAMC | Augusta, Georgia |
| Gulf Coast Veterans HCS | Biloxi, Mississippi |
| Birmingham VAMC | Birmingham, Alabama |
| Cheyenne VAMC | Cheyenne, Wyoming |
| Cincinnati VAMC | Cincinnati, Ohio |
| William Jennings Bryan Dorn VAMC | Columbia, South Carolina |
| Chalmers P Wylie Ambulatory Care Center | Columbus, Ohio |
| Martinsburg VAMC | Martinsburg, West Virginia |
| VA Hudson Valley HCS | Montrose, New York |
| Northport VAMC | Northport, New York |
| Aleda E. Lutz VAMC | Saginaw, Michigan |
| VA Caribbean HCS | San Juan, Puerto Rico |
| St. Cloud VAMC | St. Cloud, Minnesota |
| Central Texas Veterans HCS | Temple, Texas |
| Tomah VAMC | Tomah, Wisconsin |
| West Palm Beach VAMC | West Palm Beach, Florida |

*Source: OIG survey analysis.*

# Appendix C: Office of the Under Secretary for Health Memorandum

## Department of Veterans Affairs Memorandum

Date: September 18, 2024

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Inadequate Staff Training and Lack of Oversight Contribute to Veterans Health Administration's (VHA) Suicide Risk Screening and Evaluation Deficiencies (VIEWS 12078853)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report, Inadequate Staff Training and Lack of Oversight Contribute to VHA's Suicide Risk Screening and Evaluation Deficiencies. VHA concurs with recommendations 1-6 and provides action plans in the attachment.

2. VHA is committed to improving the delivery of mental health services across the system and preventing Veteran suicide. VHA will continue to ensure that Suicide Prevention is a top clinical priority in the organization.

3. Initiated in 2018, VHA's implementation of universal suicide risk screening, across all healthcare settings, is the largest known implementation of suicide risk screening and evaluation in the nation. While this standardized process of identifying suicide risk, known as VA Suicide Risk Identification Strategy, has been associated with increased mental health treatment follow-up, particularly for those Veterans not previously engaged in mental health services in the prior year (Gujral, Bahraini, Brenner LA, et al. 2023 - PubMed (nih.gov)), there is more to do. VHA appreciates the recommendations provided by the OIG, as the shared goal is to strengthen screening and evaluation processes to mitigate the risk of suicide.

4. As a high reliability, learning organization, VHA has engaged in an iterative process to examine implementation and improve uptake of the VA Suicide Risk Identification Strategy. VHA is actively driving improvements in processes and implementation through strategic partnerships and data-driven initiatives. VHA is focused on enhancing performance measurement, refining policies, and implementing targeted strategies to increase screening and evaluation rates.

5. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vha10oicgoalaction@va.gov.

*(Original signed by:)*

Shereef Elnahal M.D., MBA

[OIG comment: The OIG received the above memorandum from VHA on September 24, 2024.]

# Office of the Under Secretary for Health Response

**VETERANS HEALTH ADMINISTRATION (VHA)**
**Action Plan**

**OIG Draft Report, Inadequate Staff Training and Lack of Oversight Contribute to Veterans Health Administration's Suicide Risk Screening and Evaluation Deficiencies**
**(OIG Project Number 2023-02939-HI-1381)**

**Recommendation 1. The Under Secretary for Health ensures that required suicide risk and intervention training includes suicide risk identification screening and evaluation requirements, procedures, and instruction.**

**VHA Comments:** Concur

The Office of Suicide Prevention (OSP) will review existing suicide risk and intervention trainings to ensure that information about suicide risk screening and evaluation requirements, procedures, and instruction are provided via a required training. To close this recommendation, OSP will provide evidence of inclusion of suicide risk identification screening and evaluation requirements, procedures, and instruction within appropriate trainings.

Target Completion Date: August 2025

**Recommendation 2. The Under Secretary for Health considers establishing benchmarks for suicide risk screening and evaluation that reflect the clinical importance of suicide risk identification requirements and takes action as warranted.**

**VHA Comments:** Concur

OSP will consider establishing benchmarks that reflect the clinical importance of suicide risk screening and evaluation. To close this recommendation, OSP will provide evidence that supports consideration for establishing data informed benchmarks for suicide risk screening and evaluation.

Target Completion Date: February 2026

**Recommendation 3. The Under Secretary for Health ensures monitoring of adherence to suicide risk identification screening and evaluation setting-specific requirements.**

**VHA Comments:** Concur

OSP and the Office of the Assistant Under Secretary for Health for Operations (Operations) will review existing mechanisms for monitoring adherence of suicide risk identification screen and evaluation setting-specific requirements. Enhancements to monitoring efforts will be made, as warranted, and established processes followed to develop, test, and implement any changes to adherence monitoring. To close this recommendation, OSP will provide evidence that reflects enhancements to mechanisms

for monitoring adherence of setting-specific suicide risk screening and evaluation requirements.

Target Completion Date: February 2026

**Recommendation 4. The Under Secretary for Health ensures actions taken to address barriers to completing suicide risk screening and evaluation are effective to increase adherence to annual and setting-specific requirements in all clinical settings.**

**VHA Comments:** Concur

OSP and Operations will review barriers that impact adherence to suicide risk screening and evaluation requirements as identified in the report. To close this recommendation, OSP will provide evidence that reflects a plan to address barriers of adherence to suicide risk screening and evaluation.

Target Completion Date: February 2026

**Recommendation 5. The Under Secretary for Health ensures non-mental health clinical specialty leaders are aware of and adherent to the suicide risk identification screening and evaluation requirements.**

**VHA Comments:** Concur

OSP and Operations will review and reiterate suicide risk screening and evaluation policy requirements and related metrics with non-mental health clinical specialty leaders. To close this recommendation, OSP will provide evidence that demonstrates enhanced communication and adherence to these requirements by non-mental health clinical specialty areas.

Target Completion Date: February 2026

**Recommendation 6. The Under Secretary for Health ensures clearly identified responsibilities for suicide risk identification screening and evaluation adherence monitoring and oversight.**

**VHA Comments:** Concur

OSP and Operations will review existing suicide risk identification screening and evaluation policy responsibilities related to adherence monitoring and oversight. To close this recommendation, OSP will provide evidence that demonstrates enhanced communication of responsibilities for oversight and monitoring of suicide risk identification screening and evaluation requirements.

Target Completion Date: February 2026

# OIG Contact and Staff Acknowledgments

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